Arizona Medical Board
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February 9, 2007

Cliff J. Vanell, Director
Office of Administrative Hearings
1400 W. Washington Street, Suite 101
Phoenix, Arizona 85007

Re: Arizona Medical Board vs. Marvin Gibbs, M.D.
Case No.: 06A-13736-MDX

Dear Mr. Vanell:

The Arizona Medical Board ("Board") considered the Administrative Law Judge's ("ALJ") Recommended Decision in this matter at its February 2007 Board meeting. The Board voted as follows:

Findings of Fact: The Board accepted all the ALJ's Findings of Fact.

Conclusions of Law: The Board accepted Conclusions of Law 1 through 18. The Board deleted paragraph 19 because it was not a Conclusion of Law.

Order

The Board adopted the recommendation that Dr. Gibbs be suspended for time served. The Board added a one-year probationary period for random chart reviews. The probation was added due to Dr. Gibbs' history with the Board and the need for oversight of Dr. Gibbs.

The Board deleted the last portion of the recommended Order regarding dismissing two of the allegations because the Board does not individually dismiss allegations and the Conclusions of Law clearly state which of the allegations were sustained.

Very truly yours,

Timothy C. Miller,
Executive Director

Enclosure (original ALJ Decision)

cc: Daniel P. Jantsch, Esq. (w/out enc.)
Marvin Gibbs, M.D. (w/out enc.)
Dean E. Brekke, Assistant Attorney General (w/out enc.)

STATE OF ARIZONA

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

IN THE MATTER OF : **Marvin Gibbs, M.D.,** **Holder of License No. 13736** **For the Practice of Medicine** **In the State of Arizona**	**No. 06A-13736-MDX** **ADMINISTRATIVE LAW** **JUDGE** **DECISION**

HEARING: November 16, 2006, adjourned and reconvened on November 17, 2006

APPEARANCES: State: Anne Froedge, Assistant Attorney General, represented the STATE OF ARIZONA MEDICAL BOARD. Testifying were Meghan Hinckley, BOARD Senior Investigator, and Taz Harmon, M.D., BOARD Outside Medical Consultant. Respondent: *Olson Jantsch & Bakker P.A.*, Daniel Jantsch, Esq., appeared for Marvin Gibbs, M.D. In addition to Dr. Gibbs, the following testified: J.T., former patient; M.M., former patient/employee; R.Q., former patient/employee; J. N, former patient; Gregory Mohammed, M.D.; Peter Matthews, M.D.; and Jamie Kapner, M.D.

ADMINISTRATIVE LAW JUDGE: Gary B. Strickland

JURISDICTION

This is a proceeding commenced by the STATE OF ARIZONA MEDICAL BOARD (the "BOARD"), as authorized by Arizona Revised Statutes ("A.R.S.") Title 32, Chapter 13, Article 3 and Title 41, Chapter 6, Article 10, to receive evidence concerning the *Board's* intent to exercise discipline of the license of Marvin Gibbs, M.D., (hereinafter also "the Doctor" or "the licensee") in the practice of allopathic medicine within the State of Arizona. The Doctor is the subject of a complaint implicating his professional integrity in the treatment of a patient identified herein as "J.Z."[1]

[1] Reference to the subject patient and all other patients identifies only the patient's initials, in an effort to protect the individual's confidentiality.

Having heard the testimony of the witnesses and having read and considered the entire record,[2] Administrative Law Judge ("ALJ") Gary B. Strickland submits this RECOMMENDED DECISION AND ORDER to the Executive Director of the *Board*.

FINDINGS OF FACT

1. The ARIZONA MEDICAL BOARD has been delegated by the legislature the regulatory oversight and control of the practice of aleopathic medicine in the State of Arizona.

2. Marvin Gibbs, M.D. holds License No. 13736 issued by the BOARD on November 26, 1982, most recently renewed on December 17, 2004.

PROCEDURAL BACKGROUND

3. The present matter arises out of a Complaint that was filed to the BOARD by another licensee, Nadeem Rahman, M.D. (Urologist), on or about January 26, 2006. The Complaint was asserted against Marvin Gibbs, M.D. *Universal Health-Wellness Center, Inc.*[3]

4. The BOARD, by its Senior Medical Investigator Meghan B. Hinckley, informed Dr. Gibbs of the Complaint in a writing dated March 14, 2006.[4] The allegation of wrongdoing was encapsulated as follows:

> 1. Failure to appropriately treat erectile dysfunction, which lead (*sic*) to a *priaprism*[5] in the patient for 1 week.

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[2] The parties stipulated that the official record consists of that record having been memorialized and certified by the court reporter, the testimony and argument set forth by the parties' witnesses and their representatives, respectively, along with the exhibits that were offered at the hearing and documentation in the BOARD'S case file. The BOARD offered eighteen (18) exhibits, identified S-1 through S-18. Doctober Gibbs offered two (2) sets of exhibits into the record, marked R-1 (with 25 subsets) and R-2 (with subsets R-2A through R-2O) . Each of the exhibits was admitted. **All exhibits are ordered sealed.**

Hereinafter, references to the court reporter's transcript are identified as follows: "Transcript ("TR") page ("p"), line ("ln") or lines ("lns.").

[3] Exhibit S-1.

[4] Exhibit S-2.

Dr. Gibbs was afforded time to respond to the allegation not later than March 28, 2006.

5. Dr. Gibbs filed a response to the Complaint on March 14, 2006 asserting therein that the subject patient's questioned erection had lasted sixteen (16) hours as a result of the patient's non-compliance with written and verbal instructions previously given to him by Dr. Gibbs and his staff vis-à-vis dosage and necessity to contact the doctor should an erection exceed two (2) hours in duration.[6]

6. On May 14, 2006, Taz Harmon, M.D. (Outside Medical Consultant), upon request of the BOARD, issued a MEDICAL CONSULTANT REPORT AND SUMMARY wherein he revealed findings and opinions based upon his examination of the relevant medical records. Dr. Harmon concluded that Dr. Gibbs had failed the standard of care for the treatment of sexual dysfunction ("SD"), including premature ejaculation ("PE") under *American Urologic Association* ("AUA") guidelines by failing to prescribe less invasive treatment available for the treatment of PE. Based on his review of the medical records, Dr. Harmon further inferred that the "treatment given to J.Z.[7] may have permanently and significantly reduced his future sexual function and ability."[8]

7. Thereafter, Mark Nanney, M.D. issued a "Chief Medical Consultant Summary"[9] on May 25, 2006 wherein he opined:

> From my perspective I do not see that the patient [J.Z.] has premature ejaculation or erectile dysfunction based upon the history obtained. He obviously has some sexual complaint but it was not adequately explored. His history suggests he does not get along with his wife which will certainly impact his sexual performance.

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[5] A *priaprism* is defined by one medical authority as follows: "persistent abnormal erection of the penis, usually without sexual desire, and accompanied by pain and tenderness." *See* DORLAND'S ILUSTRATED MEDICAL DICTIONARY 1456 (29th ed.2000).

[6] Exhibit S-3.

[7] For purposes of patient confidentiality, the subject patient is referred to only by his initials, here J. Z.

[8] Exhibit S-5.

[9] Exhibit S-11.

On a final note – the records are nearly illegible.

Dr. Nanney recommended that a Staff Investigational Review Committee ("SIRC") convene for the issuance of a report.

8. On May 31, 2006, the BOARD, by and through Medical Investigator Hinckley, issued a "Statutory Notice Letter"[10] wherein and whereby Dr. Gibbs was officially informed of allegations of statutory violations then pending. The allegations subsisted in the following:

- Failure to appropriately treat premature ejaculation and erectile dysfunction leading to possible permanent damage to the patient.
- Failure to appropriately treat a *priaprism*, a complication of erectile injections.
- Treatment of a patient or disease outside of the physician's scope of practice.
- Inadequate/illegible patient medical records.

The letter further informed the doctor of the pending alleged statutory violations:

- A.R.S. § 32-1401(27)(e) – Failing or refusing to maintain adequate records on a patient.
- A.R.S. § 32-1401(27)(q) – Any conduct or practice that is or might be harmful or dangerous to the health of the patient or public.
- A.R.S. § 32-1401(27)(ll) – Conduct that the BOARD determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.

9. The SIRC issued its "SIRC Recommendation" on August 16, 2006.[11] The "SIRC Recommendation" found that Dr. Gibbs had prescribed invasive treatment for a patient allegedly suffering from PE when the standard of care required a less invasive modality of behavior modification or the administration of psychotropic medication. The SIRC concluded that Dr. Gibbs' treatment of the patient with penile injection failed the standard of care for the treatment of PE. The SIRC further found that J.Z. was actually harmed as a result of the treatment in that he was deemed by the SIRC as not then

[10] Exhibit S-8.

[11] Exhibit S-14.

capable of achieving a full erection.

10. The SIRC recommended a finding of statutory violation and found as aggravating factors (1) that male sexual dysfunction does not fall within the scope of practice of an OB/GYN, and (2) Dr. Gibbs' license disciplinary history. The SIRC recommended a summary suspension of the license.[12]

11. The BOARD issued "Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of [the Gibbs] License" on August 25, 2006.[13] After having met on August 24, 2006 to review the SIRC findings and recommendation, along with other relevant data, the BOARD summarily suspended License No. 13736 determining that Dr. Gibbs' continued practice posed a threat to public health, safety, and welfare requiring emergency action authorized by A.R.S. § 32-1451(D).

12. The BOARD'S action was premised upon finding violation of A.R.S. § 32-1401(27(e), (ll), and (q). Further, in making its decision summarily to suspend the license, the BOARD considered Dr. Gibbs' prior disciplinary history as presenting aggravating factors; the BOARD'S issuance of a "Decree of Censure" in 2003 and restriction on Dr. Gibbs' ability to prescribed Schedule II and III controlled substances necessitated by discovery of incompetent internet prescription activity,[14] the Drug Enforcement Agency's (DEA") revocation of Dr. Gibbs' prescribing certificate on February 20, 2004,[15] and Dr. Gibbs' loss of hospital obstetrical privileges in 2003 and receipt of a BOARD-issued "Letter of Reprimand" on December 12, 2005 relating thereto.[16] The BOARD informed Dr. Gibbs of his right to a formal Hearing of the charges against him.

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[12] Exhibit S-14.

[13] Exhibit S-15.

[14] Exhibit S-16.

[15] Exhibit S-18.

[16] Exhibit S-17.

THE TESTIMONY OF THE WITNESSES
THE BOARD'S CASE

Meghan Hinckley

13. BOARD Senior Investigator Meghan Hinckley testified concerning her role in the investigation of the Rahman Complaint. The witness informed that the doctor's handwritten charting was barely legible[17] and that she was constrained to refer the matter to an outside consultant, Taz Harmon, M.D. because the objections raised addressed the quality of care afforded a patient.[18]

14. Ms. Hinckley acknowledged that Dr. Gibbs was not called in for an investigative interview,[19] albeit she talked to Dr. Rahman, as is typical,[20] to clarify what the Complainant's concerns were.[21]

15. Ms. Hinckley also acknowledged that her office did not at any time contact patient J.Z. to elicit information either regarding the treatment that Dr. Gibbs had prescribed or the patient's post-treatment condition.[22] Neither did her office contact the interpreter to discuss what communications Dr. Gibbs may have had with J.Z. through the office interpreter.[23]

Taz Harmon, M.D.

16. Taz Harmon, M.D., board certified in urologic surgery,[24] currently practicing adult urologic surgery,[25] and licensed in Arizona since 1999 testified. Dr.

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[17] November 16,, 2006 Hearing Transcipt (hereinafter, "11/16/06 or 11/17/06 HT) at p.36, lns. 6-9.

[18] 11/16/06 HT at p.37, lns.3-9.

[19] 11/16/06 HT at p.37, lns.3-9.

[20] 11/16/06 HT at p.48, ln.22 through p. 49, ln.2.

[21] 11/16/06 HT at p.35, lns.14-17.

[22] 11/16/06 HT at p.49, lns.18-20; at p.59, lns.13-18.

[23] 11/16/06 HT at p.49, lns.3-11.

[24] 11/16/06 HT at p.66, lns.1-13.

[25] 11/16/06 HT at p.67, lns.6-7.

Harmon gave his opinions as the Outside Medical Consultant ("OMC") requested by the BOARD to review the medical record of Dr. Gibbs' treatment of patient J.Z.

17. Dr. Harmon, who treats fifteen (15) to twenty (20) patients a month for male sexual dysfunction,[26] among whom he considers those complaining of PE a "subset,"[27] stressed his perception that PE should be differentiated from erectile dysfunction ("ED") as a condition requiring treatment.[28] According to this expert, PE is not specifically a subset of ED.[29] In his practice, Dr. Harmon diagnoses the causes of PE as (1) performance anxiety and/or (2) over-stimulation.[30] For the condition, he typically would variously prescribe the following : A) utilization of the "squeeze technique;" B) administration of anti-depressants (serotonin reuptake inhibitors ("SRIs"); C) use of analgesics such as *EMLA Cream.*[31]

18. It is Dr. Harmon's opinion that penile injection therapy (intra-cavernosal injection therapy - "ICI" - sometimes "ICP") is an invasive therapy that should not be used for the treatment of orgasmic dysfunction PE unless an adequately informed consent is obtained;[32] the standard of care requires that the physician first assess the patient through history and physical and then proceed to a non-invasive modality before moving on to something more invasive.[33]

19. Having reviewed Dr. Gibbs' records in the treatment of patient J.Z., the emergency room records from *St. Joseph's Hospital* whereat the patient was treated for his *priaprism* of January 25, 2006, and records from *Urology Associates* whereat J.Z. was later treated by Dr. Rahman, Dr. Harmon concludes that patient J.Z. suffered from

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[26] 11/16/06 HT at p.67, ln.24 through p.70, ln.5

[27] 11/16/06 HT at p.68, lns.6-11.

[28] 11/16/06 HT at p.70, ln.19 through p.71, ln.8

[29] 11/16/06 HT at p.71, lns.13-16.

[30] 11/16/06 HT at p.68, lns.15-20.

[31] 11/16/06 HT at p.68, ln.21 through p. 69, ln.22.

[32] 11/16/06 HT at p.108, lns.5-23.

[33] 11/16/06 HT at p.70, lns.13-15.

orgasmic dysfunction PE; the patient did not suffer from ED as is manifested by his own assertion that he that he could maintain for thirteen (13) minutes prior to ejaculation.[34]

20. Penile injection therapy should not be prescribed for the treatment of PE;[35] the regimen poses risks that blood may clot and create a fibrosis of the penis, thereby inhibiting channels from continuing to fill with blood and possibly resulting in a permanent erectile dysfunction.[36]

21. The *American Urological Guidelines*[37] do not recommend intra-cavernosal injection therapy ("ICI") for the treatment of PE. Rather, the guidelines recommend a preferred treatment consisting either of (1) serotonin reuptake inhibitors ("SRIs"), or (2) topical anesthetics. Dr. Harmon acknowledged that the *American Urological Guidelines* do not establish the standard of care for the treatment of ED or PE; they are guidelines.[38]

22. The treatment that Dr. Gibbs prescribed for J.Z. fell below the standard of care.[39] According to Dr. Harmon, the Doctor inappropriately treated J.Z. for PE with ED medications; the patient was treated for PE by the doctor having prescribed a *priaprism*, a prolonged erection.[40] The fundamental problem with the treatment was that J.Z. experienced a prolonged erection even on the second lower dose prescribed by the doctor.[41]

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[34] 11/16/06 HT at p.72, ln.22 through p.83, ln.2; p.97, ln.23.

[35] 11/16/06 HT at p.120, lns.7 and 8.

[36] 11/16/06 HT at p.75, lns.8-16.

[37] Exhibit S-12.

[38] 11/16/06 HT at p.107, lns.4-8.

[39] 11/16/06 HT at p.75, lns.23-25; p.83, ln.25 through p.84, ln.2.

[40] 11/16/06 HT at p.129, lns.4-9; p.125, ln. 14 through p.126, ln.1.

[41] 11/16/06 HT at p.135, lns.14-16.

23. Further, Dr. Gibbs erred by not initiating the ICI with the considered lowest dosage.[42] The doctor's use of a "Tri-mix" with prostaglandin at a dosage greater than the lower obtainable, produced a greater risk of *priaprism*.[43]

24. Still further, based upon his patient records, Dr. Gibbs failed to discuss various treatment options with J.Z.[44]

25. Moreover, albeit Dr. Gibbs' patient records manifest acceptable subjective recounting, the remaining portions of the records are so illegible as to be indecipherable. In this, Dr. Gibbs also failed the standard of care.[45]

26. Compounding the deficiency in care is Dr. Harmon's understanding that J.Z. is Spanish speaking only and is illiterate. Even the presence and use of the services of one conversant in both Spanish and English is problematic. It appears questionable whether J.Z. gave an informed consent to ICI treatment.[46]

27. It is Dr. Harmon's opinion that J.Z. suffered injury;[47] he had to be irrigated at *St. Josephs Hospital* and, according to the complaining physician, Dr. Rahman, he was unable thereafter to experience spontaneous erection.[48]

28. Dr. Harmon admitted that he did not conduct a face-to-face interview with Dr. Gibbs prior to issuing his opinions to the BOARD despite acknowledged discrepancy between the medical record and the explanatory response of the doctor; neither did he conduct any investigative interviews.[49] It is Dr. Harmon's conclusion that because the Doctor should not have prescribed ICI for a PE diagnosis in the first place, adequate

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[42] 11/16/06 HT at p.81, lns.18-25.

[43] 11/16/06 HT at p.80, ln.5 through p.82, ln.3.

[44] 11/16/06 HT at p.104, ln.21 through p.105, ln.1; p.135, lns.22-25.

[45] 11/16/06 HT at p.88, ln. 3 through p.89, ln.2.

[46] 11/16/06 HT at p.89, ln. 3 through p. 90, ln.17.

[47] 11/16/06 HT at p.75, lns.17-22; p.136, ln. 19 through p.137, ln.14.

[48] *See* Exhibit S-12: "Chief Medical Consultant Summary" "35 year old patient is now unable to achieve full erection."

[49] 11/16/06 HT at p.116, lns.12-22; p.117, ln.24 through p.119, ln.23.

physician directive and compliance therewith pose irrelevant issues.[50] As far as an informed consent, "if it's not written and documented in the chart, then it didn't happen"[51]

29. Further, Dr. Harmon admitted that he had been unaware that Dr. Gibbs had attended a three-day seminar whereat the Doctor had been trained in ICI therapy and for which he received a certificate.[52]

THE RESPONDENT'S CASE
Former Patients and Employees

Former Patient J.T

30. Dr. Gibbs' former patient J.T. testified relating how Dr. Gibbs treated him for PE. He indicated that Dr. Gibbs had "explained things to me real good."[53] The Doctor had warned of risks associated with the use of penile injection therapy[54] after he had told him of the availability of SRI's and desensitizing creams.[55] The patient had previously used *Cialis* prescribed by his previous treating physician, to no effect; he had also tried a desensitizing cream without satisfaction.[56]

31. According to J.T., a healthy 44 year-old male, Dr. Gibbs admonished him to contact him should he experience an erection beyond two hours; he did not experience any erections lasting that long.[57]

Former Patient/Employee R.Q.

32. Another former patient, R.Q., a 63 year-old who had experienced problems with PE, testified that Dr. Gibbs' administration of penile injections "solved" his

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[50] 11/16/06 HT at p.119, lns.14-23.

[51] 11/16/06 HT at p.120, lns.21-22.

[52] 11/16/06 HT at p.116, ln.23 through p.117, ln.9.

[53] 11/16/06 HT at p.142, lns.15-18.

[54] 11/16/06 HT at p.142, lns.19-23.

[55] 11/16/06 HT at p.141, lns.9-13.

[56] 11/16/06 HT at p.139, ln.24 through p. 140, ln.10; p.144, lns.2-10; p.24, ln.24 through p.147, ln.7.

[57] 11/16/06 HT at p.143, lns.7-18.

concerns. Having previously had doctor(s) prescribe ointments and SRI's to no positive effect, Dr. Gibbs not only "solved" his PE problem but also induced him to enter the Doctor's employ at the clinic.[58]

33. R.Q., who speaks Spanish as his primary language, worked for Dr. Gibbs from June 2005 through August 2006.[59] His job was to answer the telephone, receive patients (among whom 50-65% were Spanish speaking only), assist the patients in filling out the necessary new patient health questionnaire, and explain the forms provided to them.[60]

34. R.Q., who does not possess any certification either as a medical assistant or in nursing,[61] gave his opinion that Dr. Gibbs was always clear about making the patient fully-informed about procedures and warnings.[62]

Former Patient/Employee M.M.

35. M.M. was employed by Dr. Gibbs from May to July 2006 on an hourly basis to provide Spanish interpretive services to patients.[63]

36. M.M. recalls that Dr. Gibbs offered the patients a three-fold treatment alternative: A) lubricants; B) SRI's; and C) ICI. The doctor always informed the patient of the risks that attended ICI.[64]

Former Patient J.N.

37. J.N., a twenty-nine (29) year-old male, was treated by Dr. Gibbs for ED.[65] He had previously had *Viagra* prescribed for him by his family practitioner which he used for three to five months without success.

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[58] 11/16/06 HT at p.190, ln.17 through p.191, 12.

[59] 11/16/06 HT at p.189, lns.17-25.

[60] 11/16/06 HT at p.190, lns.7-16.

[61] 11/16/06 HT at p.201, lns.1-7.

[62] 11/16/06 HT at p.198, ln.14 through p.200, ln.9; p.204, lns.12 -24.

[63] 11/16/06 HT at p.210, ln.10 through p.214, ln.13.

[64] 11/16/06 HT at p.217, lns.3-20..

38. When he visited Dr. Gibbs, the Doctor recommended either the use of a desensitizing cream, *Viagra*, or an antidepressant.[66] J.N. did not want any of those treatments.[67] Having previously been to the *Boston Medical Clinic*, the patient preferred the use of injection therapy.

39. Having been treated by Dr. Gibbs with the injection therapy resulting in no *priaprism* experience and with erections lasting no more than 35 to 50 minutes,[68] J.N. proclaims Gibbs' thoroughness as "the best I ever had."[69]

Physician Experts

Gregory Mohammed, M.D.

40. Gregory Mohammed, M.D., a General Surgeon not board certified[70] not having taken the exam,[71] and who has known Dr. Gibbs on a professional basis since 1994,[72] testified. Dr. Mohammed has been employed by *Boston Medical Clinic* for the past two years, an entity that treats patients for erectile dysfunction and performance anxiety primarily with intra-corporal injections.[73] One-quarter to one-third of his patients are treated for PE; of those so treated, the majority are prescribed ICI therapy.[74] His initial training at *Boston Medical* lasted two weeks.[75]

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[65] 11/17/06 HT at p.267, ls.11-12; p.269, lns.11-22; p.277, lon.s.2-4.

[66] 11/17/06 HT at p.270, lns.12-16.

[67] 11/17/06 HT at p.271, ln.3.

[68] 11/17/06 HT at p.274, lns.2-12.

[69] 11/17/06 HT at p.272, ln.17; p.274, lns.18-23.

[70] 11/16/06 HT at p.150, ln.10.

[71] 11/16/06 HT at p.165, lns.11-14.

[72] 11/16/06 HT at p.172, ln.21 through p.173, ln.14.

[73] 11/16/06 HT at p.150, lns.13 through p.151, ln.12.

[74] 11/16/06 HT at p.167, lns..6-11.

[75] 11/16/06 HT at p.166, lns.8-14.

41. Dr. Mohammed does not advocate the use of SRI's for the treatment of ED/PE; the patient generally is concerned with attendant stigmatization and the treatment itself takes six weeks to demonstrate effectiveness.[76]

42. For Dr. Mohammed, the standard of care requires (1) that a history and physical be conducted; (2) that a physician assessment be made; and (3) that various options be discussed with the patient. The use of intra-corporal injection ("ICI/ICP")[77] therapy is very acceptable in Arizona for the treatment of PE. The standard of care is to prescribe ICI for those not having experienced success with the use of alternative less-invasive treatment.[78]

43. Having reviewed the medical records in the treatment of patient J.Z. and interviewed the Doctor on two occasions, Dr. Mohammed is of the opinion that Dr. Gibbs is very qualified to treat ED and PE according to the community standard.[79] Further, it is his opinion that ICI was appropriately recommended as a treatment for J.Z.[80]

44. After J.Z. had experienced what Dr. Mohammed considered the first of his *priaprisms* (through noncompliance-what amounted to a double dose self-administration resulting in a sixteen (16) hour erection), Dr. Gibbs took appropriate steps to avoid reoccurrence.[81]

45. At the time that he was testifying, Dr. Mohammed revealed that he was unaware that J.Z. had experienced a five (5) hour erection on January 4, 2006, the second day of his treatment. That being the case, Dr. Mohammed is of the opinion that the Doctor correctly "titrated down" the dosage on January 4, 2006.[82]

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[76] 11/16/06 HT at p.151, ln.25 through p.153, ln.15.

[77] The designations "ICI/ICP" are interchangeable.

[78] 11/16/06 HT at p.153, ln.16 through p.154, ln.18.

[79] 11/16/06 HT at p.155, ln.1 through p.156, ln.5.

[80] 11/16/06 HT at p.188, lns.2-8.

[81] 11/16/06 HT at p.156, ln.17 through p.159, ln.10.

[82] 11/16/06 HT at p.174, ln.6 through p.175, ln.19.

46. Dr. Mohammed defines a *priaprism* as (1) a full erection lasting longer than four (4) hours; and (2) accompanied by complaints of pain.[83]

47. Dr. Mohammed finds it significant that patient J.Z. signed an informed consent.[84] However, he emphasizes that it is imperative that a doctor discuss with the patient the risks and procedures before the consent may actually result from an informed understanding.[85]

48. ICI has been prescribed by the medical community for the treatment of PE for more than fifteen (15) years.[86]

49. Dr. Mohammed is unaware whether the AUA guidelines do or do not allow ICI therapy for the treatment of PE.[87]

50. It is not substandard for a patient to experience an ICI-induced erection for three (3) hours and twenty (20) minutes upon administration of a test dose, as was the case with Dr. Gibbs' initial administration to J.Z.[88]

51. It is not necessary to start a patient on the lowest possible dose as a trial dose; it depends on what is revealed through history and physical.[89] Further, the distinction "Tri-mix" or "Bi-mix" is not of consequence regarding propensity to develop *priaprism*; it depends on dosage concentration.[90] The strength of the medication is what may or may not increase a risk for *priaprism.*[91]

52. Dr. Mohammed indicated that he would have routinely performed a *Dopplar* study of the patient before proceeding to an ICI regimen. To do so falls within

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[83] 11/16/06 HT at p.159, ln.11 through p.160, ln..5.

[84] 11/16/06 HT at p.156, ln.24 through p.157, ln.5. Exhibit R-2(F).

[85] 11/16/06 HT at p.187, lns.9-13.

[86] 11/16/06 HT at p.160, lns.16-19.

[87] 11/16/06 HT at p.170, ln.23 through p.171, ln.10.

[88] 11/16/06 HT at p.162, ln.14 through p.163, ln.9.

[89] 11/16/06 HT at p.164, lns.1-7.

[90] 11/16/06 HT at p.168, ln.18 through p.170, ln.3.

[91] 11/16/06 HT at p.178, lns.15-19.

the standard of care;[92] but, not to do so does not necessarily fall below the standard of care.[93] There is nothing in the medical chart that would indicate that Dr. Gibbs performed a *Dopplar* study in his treatment of J.Z.[94]

Peter Matthews, M.D.

53. Peter Matthews, M.D., a board-certified urologist[95] testified. His patient class consists predominantly of older adults and the modalities he prescribes for ED and PE consists primarily of hormone replacement, medications, ICI, and, in rare instances, penile prostheses.[96]

54. Having interviewed Dr. Gibbs, Dr. Matthews is of the opinion that the Doctor's treatment capabilities are "better than most."[97] He believes that, with regard to prescribing the proper dosage, Dr. Gibbs' approach is more rigorous than most community-based urologists.[98] However, it is Dr. Matthews' opinion that Dr. Gobbs' treatment of J.Z. fell within the standard of care.[99]

55. It is Dr. Matthews' opinion that penile injection therapy is not prohibited for the treatment of PE.[100] And, it is not necessary that an interpreter working in a doctor's office have medical training.[101]

56. Dr. Matthews treats eight (8) to ten (10) patients for PE yearly.[102] In the past three years he has not treated a PE patient with injection therapy.[103]

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[92] 11/16/06 HT at p.180, lns.1-14.

[93] 11/16/06 HT at p.182, lns.11-17.

[94] 11/16/06 HT at p.180, lns.12-14.

[95] 11/16/06 HT at p.236, lns.24-25.

[96] 11/16/06 HT at p.226, ln.11 through p.227, ln.3.

[97] 11/16/06 HT at p.227, ln.16 through p. 228, ln.3.

[98] 11/16/06 HT at p.235, lns.4-12; p. 236, ln.s. 11-13.

[99] 11/16/06 HT at p.236, lns.14-16.

[100] 11/16/06 HT at p.230, lns.10-16; p. 239, ln. 4 through p.240, ln.18.

[101] 11/16/06 HT at p.244, ln.22 through p.245, ln.24.

57. Dr. Matthews defines a *priaprism* as any prolonged erection, with or without pain, lasting beyond the period required for sexual activity.[104]

58. Dr. Matthews typically would prescribe a "Tri-mix" at the lowest dose possible; probably 0.1cc for a healthy young man.[105] *Hypoxia* and tissue deterioration are the risks that are associated with *priaprism.*[106]

Jamie Kapner, M.D.

59. Jamie Kapner, M.D. testified by videotaped deposition.[107]

60. Dr. Kapner, an Arizona licensee since 1983, is board-certified in urology, having twice been recertified.[108]

61. Dr. Kapner's practice includes treatment for male sexual dysfunction, PE as well as ED,[109] although he has never attended any trainings specifically addressing penile injection therapy.[110] His understanding of the proper method of treating a patient with penile injection therapy has been gained though self-study.[111]

62. PE is presently vaguely defined.[112] But, it is the most common dysfunction in men under forty (40) years old.[113] Because of the nature of his practice, Dr. Kapner

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[102] 11/16/06 HT at p.237, lns.15-21.

[103] 11/16/06 HT at p.238, lns.9-15.

[104] 11/16/06 HT at p.241, ln.22 through p.242, ln.3.

[105] 11/16/06 HT at p.247, ln.8 through p.249, ln.16.

[106] 11/16/06 HT at p.242, lns.12-23.

[107] Dr. Kapner was unavailable to testify at the Hearing; he was scheduled to be out-of-the-country. Exhibit R-O. References hereinafter to Dr. Kapner's videotaped deposition are identified as follows: KVD – p.; lns.

[108] KVD - p.5; lns. 11-22.

[109] KVD - p.6; ln. 23 through p. 7, ln. 3.

[110] KVD - p.32; lns. 10-23.

[111] KVD - p.49; lns. 11-19.

[112] KVD - p.8; lns. 17-19 and p.9; lns. 11-24 and p. 36; lns. 14-24.

[113] KVD - p.9; lns. –102

typically treats a PE patient with injection therapy on a yearly basis,[114] probably one or two who present in circumstances similar to J.Z.[115]

63. The accepted treatment for PE includes the following modalities: (1) the "stop-and-go" technique; (2) antidepressants or antianxiety medications; (3) desensitizing topical anesthetics; (4) extending erection through use of *Viagra*, *Cialis*, *Levitra*; (5) penile injection; (6) the "Muse;" and (7) penile implants.[116]

64. The standard of care does not require that one modality be tried first before prescribing a different modality.[117] The correct mode of treatment depends upon the patient's history and goals.[118] Dr. Kapner does not rely on the AUA guidelines for an assessment of the standard of care in the treatment of ED/PE.[119]

65. Dr. Kapner regards PE as a subspecies of ED.[120]

66. Having reviewed the BOARD'S investigative file, Dr. Kapner generally believes that Dr. Gibbs' approach to dealing with "these" patients was very good.[121] He did not find anything in the record that would indicate substandard or inappropriate practice and he is of the opinion that Dr. Gibbs satisfied the standard of care in all respects.[122]

67. Dr. Kapner interviewed Dr. Gibbs face-to-face about his treatment of J.Z., as well as about his practice generally.[123]

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[114] KVD - p.36; lns. 11-14.

[115] KVD - p.37; lns. 16-21

[116] KVD - p.10; ln. 11 through p. 12; ln. 9.

[117] KVD - p.14; lns. 8-12.

[118] KVD - p.14; ln. 13, through p. 15; ln. 16.

[119] KVD - p.35; lns. 9-11

[120] KVD - p.15; ln. 17, through p. 16; ln. 1.

[121] KVD - p.16; lns. 11-24.

[122] KVD - p.17; lns. 13-19.

[123] KVD - p.18; lns. 6-14.

68. Dr. Kapner believes that Dr. Gibbs properly, through an interpreter, explained the various modalities and their risks and benefits to J.Z.[124]

69. Dr. Kapner is of the opinion that Dr. Gibbs properly, through an interpreter, explained the proper usage of the penile injection to J.Z. and the course that the patient was to follow if a *priaprism* developed.[125]

70. A *priaprism* with full erection lasting longer than four (4) to six (6) hours needs to be addressed.[126] In his practice, Dr. Kapner has never had to treat a case of *priaprism.*[127]

71. J.Z.'s January 11, 2006 sixteen (16) hour *priaprism* resulted from the patient's having administered back-to-back injections, albeit the doctor had warned against back-to-back injections.[128] When the patient came to the office on January 16, 2006 and informed Dr. Gibbs of what had occurred on January 11, the Doctor properly counseled against back-to-back administrations and modified the dosage eventually down to producing a two (2) hour erection.[129]

72. After the second *priaprism* was belatedly (after thirteen (13) hours) and non-compliantly reported by the patient on January 26, 2006, Dr. Gibbs reasonably and prudently directed the patient to 60 milligrams (four at one time) of *Sudafed* 2x's.[130]

73. Complainant Dr. Rahman's statement in the Complaint that may be interpreted that J.Z. had a continuous and persistent *priaprism* for one week cannot be validated and is incorrect.[131]

74. Dr. Gibbs appropriately treated J.Z. for his January 25, 2006 *priaprism.*[132]

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[124] KVD - p.19; lns. 3-25.

[125] KVD - p.20; lns. 16-23.

[126] KVD - p.21; lns. 2-5

[127] KVD - p.36; lns. 7-10

[128] KVD - p.22; lns. 1-25

[129] KVD - p.23; lns. 1-16

[130] KVD - p.23; ln. 24 through p. 25; ln. 25.

[131] KVD - p.27; lns. 3-14.

75. It is Dr. Kapner's opinion that Dr. Gibbs exercised sound judgment in prescribing a "Tri-mix" through penile injection for patient J.Z.;[133] it was the patient's noncompliance in the administration of the "Tri-mix" that caused the *priaprisms.*[134]

76. It is Dr. Kapner's belief that overdosage is the only cause for *priaprism* occurrence after penile injection.[135]

77. Dr. Kapner had trouble reading Dr. Gibbs' chart of J.Z.'s treatment.[136] Dr. Kapner has relied on his discussions with Dr. Gibbs, not the patient's chart, to understand that the doctor discussed all treatment options with the patient before prescribing injection therapy.[137]

Marvin Gibbs, M.D.

78. Dr. Gibbs is a fifty-eight (58) year-old board-certified OB/GYN who has been licensed in Arizona since July 1980.[138]

79. The doctor attended a three-day seminar, the "Institute for Erectile Dysfunction" in Las Vegas in April 2004[139] that addressed ED/PE issues and instructed in penile injection therapy, as well as alternative modalities for treatment. An "Institute for Erectile Dysfunction Syllabus" ("the Syllabus") was presented to the attendees.[140] In the Syllabus was included "AUA Guidelines on the Pharmacologic Management of Premature Ejaculation"[141] along with "AUA Guidelines on RX of Priaprism."[142] Dr. Gibbs received a certificate for his attendance at the *Superior Medical Solutions* seminar.[143]

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[132] KVD - p.27; ln. 15 through p. 29; ln. 21.

[133] KVD - p.30; lns. 13-17.

[134] KVD - p.46; lns. 14-20.

[135] KVD - p.40; lns. 12-24.

[136] KVD - p.43; lns. 17-25

[137] KVD - p.44; ln. 17 through p. 45; ln. 11.

[138] 11/17/06 HT at p.281, lns.2-3; p.282, lns.6-8.

[139] 11/17/06 HT at p.282, lns.14-20.

[140] Exhibit R-1. 11/17/06 HT at p.284, lns.7-9.

[141] Exhibit R-1(18).

80. It is the doctor's understanding, based on his training, that a physician's goal is to bridge the gap between the patient's latency time and that of his sexual partner.[144]

81. Albeit it is Dr. Gibbs' practice to discuss with each patient for at least ten (10) minutes the procedures available and the risks accompanying each, he has not recorded the discussion in his patient chart; "I failed to enter a progress note."[145] He did not chart all of his discussions with J.Z.[146]

82. In his treatment of patient J.Z., Dr. Gibbs followed all protocols taught at the Las Vegas seminar.[147] He prescribed a "Tri-mix" solution for the patient, the "ultra low dose formulation reserved for patients with PE," the lowest possible dose.[148]

83. Patient J.Z. signed an "informed Patient Consent"[149] on January 3, 2006. The informed consent provided the following:

> A doctor, (*sic*) will perform a history and physical evaluation targeted at your specific concern. The doctor then administers a test dose of the medication to the penis using an auto-applicator. This medication contains a combination of commonly used vasodilators including Papaverine, Phentolamine, and Prostaglandin El. It may induce an erection. A partial or full erection lasting 30-240 minutes usually results from this application. Rarely, this application may produce a full erection lasting longer than four hours. Should there be a possibility of this occurring, you will be advised on what procedures you should follow to resolve the erection. Other rare effects of this procedure include lightheadedness.

. . .

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[142] Exhibit R-1(25)

[143] Exhibit S-9. 11/17/06 HT at p.283, lns.12-22.

[144] 11/17/06 HT at p.289, lns.15-25.

[145] 11/17/06 HT at p.2341 lns.11-16.

[146] 11/17/06 HT at p.300, lns.9-10; p.341, lns.11-16.

[147] 11/17/06 HT at p.302, lns.3-8.

[148] 11/17/06 HT at p.330, lns.1-10; Exhibit R-2(G).

[149] Exhibit R-2(F). 11/17/06 HT at p.331, lns.23-25.

> I, (patient J.Z. entered his signature), fully understand the nature of the above tests and possible side effects. . . . I consent to treatment by the physician should I experience any of the above symptoms. . . .

Dr. Gibbs stated that the discussions had with the patient are more critical than are the written instructions.[150]

84. When J.Z. visited the Doctor on January 16, 2006, he reported a *priaprism* on the 11th that had occurred after he had self-administered a second (double) dose. He had done so because he was concerned that he had not properly given himself a full dose on his first attempt at self-administration.[151]

85. J.Z. reported on January 26, 2006 that he had experienced a thirteen and one-half (13½) hour *priaprism* (the one that led to the Rahman Complaint). According to the Doctor, there was no way that he could have ended up with his *priaprism* had he not then again double-dosed.[152]

86. J.Z. has moved to the State of Idaho. Out of concern for his former patient's well-being, Dr. Gibbs spoke with him on the telephone in early August and late September. The patient related that he has not experienced any pain and that everything is okay. Dr. Gibbs' wife acted as Spanish-speaking interpreter during these most recent telephonic conversations with J.Z.[153] At this time, Dr. Gibbs' wife was not employed by him. Dr. Gibbs explains that he was not practicing medicine during the conversations (at the time of the September conversation, his license had been suspended).[154]

87. It is Dr. Gibbs' understanding that doctors all over the country use drugs like *Viagra* and ICI to treat PE regardless what Drs. Harmon or Nanney may believe.[155]

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[150] 11/17/06 HT at p.303, lns.16-19.

[151] 11/17/06 HT at p.319, lns.1-22.

[152] 11/17/06 HT at p.323, ln.4 through p.325, ln.1.

[153] 11/17/06 HT at p.326, ln.15 through p.328, ln.9.

[154] 11/17/06 HT at p.342, ln.8 through p. 344, ln.17.

[155] 11/17/06 HT at p.335, ln.16 through p.336, ln.4.

88. He is certain that, based upon his experience and training, he satisfied the standard of care in his treatment of J.Z.[156] The fact that J.Z. telephoned to the doctor's office at 9:30 P.M. on the day that the test dose was administered to report his experience, as directed, is indicative that the patient understood the information that had been given to him at the office earlier that day.[157]

89. Eighty-five percent (85%) of Dr. Gibbs' patients during the relevant period of practice were Spanish-speaking only. Fifty to sixty percent (50-60%) of the patients complained of PE. Dr. Gibbs had targeted the population through his website reclaimyoursexlife.com and FM radio.[158]

90. Dr. Gibbs is of the opinion that a *Dopplar* study is not required by the standard of care in the treatment of PE.[159]

91. It is apparent that Dr. Gibbs enjoys thoroughly discussing treatment-related issues; he presents as one rather talkative.[160] If his testimony manifesting a certain verbosity is any indication, it is probable that he goes to great lengths to explain to patients procedures and risks attendant ICI and alternative modalities.

QUESTIONS PRESENTED

(1) *Whether the BOARD properly determined that Dr. Gibbs failed or refused to maintain adequate records on a patient? Were the records maintained by the doctor in his treatment of patient J.Z. so illegible and fraught with lacunae as not to enable reviewers to ascertain the treatment the doctor prescribed for the patient?*

(2) *Whether the BOARD properly concluded that Dr. Gibbs engaged in conduct in the treatment of patient J.Z. that was or might be harmful or dangerous to the health of the patient? Should the doctor have prescribed a less invasive regimen?*

(3) *Whether the BOARD properly found that Dr. Gibbs engaged in conduct in his treatment of patient J.Z that constituted gross negligence, repeated negligence or negligence resulting in harm to or death of the patient? What constitutes the standard of*

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[156] 11/17/06 HT at p.338, lns.11-15.

[157] 11/17/06 HT at p.314, ln.20 through p.315, ln.5.

[158] 11/17/06 HT at p.348, ln.4 through p.349, ln.18.

[159] 11/17/06 HT at p.355, ln.25 through p.356, ln.19; p.362., lns.18-22.

[160] His responses to questioning had to be constrained by Counsel; e.g., 11/17/06 HT at p.298, ln.21 through p.299, ln.24; p.306, ln.4 through, p.307, ln.14.; p.322, lns.12-13.

care for a patient complaining of PE? Did the doctor's treatment of patient J.Z. fall below the standard of care? What is the standard of care for the treatment of priaprism? Did the doctor's treatment of J.Z.'s priaprism(s) fall within the standard of care? Did Dr. Gibbs obtain an informed consent from J.Z. prior to his treatment?

(4) *By treating J.Z. for PE did Dr. Gibbs practice beyond the scope of his practice?*

THE BURDEN OF PERSUASION AND THE STANDARD OF PROOF

92. The burden of persuasion generally at an administrative Hearing falls to the party asserting a claim, right or entitlement or seeking to impose a penalty.[161] Further, the standard of proof is that of the "preponderance of the evidence".[162] Proof by a preponderance means that the evidence is sufficient to persuade the finder of fact that the proposition is ". . . more likely true than not."[163] The evidence taken as a whole must convince the decision maker that the party who bears the overall burden of persuasion is more probably correct on the issue(s) in dispute.[164]

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[161] *See* A.R.S. § 41-1092.07(G)(2):

> 2. At a hearing on an agency action to suspend, revoke, terminate or modify on its own initiative material conditions of a license or permit, the agency has the burden of persuasion.

See also Ariz. Admin. Code R2-19-119(B).

[162] *See Smith v. Arizona Dep't of Transp.*, 146 Ariz. 430, 432; 706 P.2d 756, 758 (App. 1985); *see also Culpepper* v. *Arizona Board of Nursing,* 187 Ariz. 431, 930 P.2d 508 (App. 1997); Ariz. Admin. Code R2-19-119(A).

[163] *In re Arnold and Baker Farms*, 177 B.R. 648, 654 (9th Cir. BAP (Ariz.) 1994). *See also*, J. LIVERMORE, R. BARTELS, & A. HAMEROFF, LAW OF EVIDENCE § 301.1(4th ed. 2000) (One party bears the overall burden of persuasion on each fact material to the party's claims and defenses. Further, the party with the burden of persuasion on a particular fact is required to satisfy the burden of production of enough qualitative evidence sufficient to support a finding of the existence of the fact, following a reasonable person standard.)

[164] *Croft v. Arizona State Bd. of Dental Examiners*, 157 Ariz. 203, 209; 755 P.2d 1191, 1197 (App. 1988) ("[A] doctor is not liable in negligence for mere mistakes in judgment in treating a patient, but is only liable where the treatment falls below the recognized standard of good medical practice. *Citation omitted.* Ordinarily, in malpractice cases, the applicable standard of care must be established by expert testimony unless the negligence is so grossly apparent that a layman could recognize it. *Citation omitted.*"); *see also Webb v. State ex rel. Ariz. Bd. of Med. Exam'rs,* 202 Ariz. 555, 560; 48 P.3d 505, 510 (App. 2002) ("Although the Board may establish the standard of professional care based upon its members' experience and expertise, the Board 'cannot base its findings . . . upon either undisclosed evidence or personal knowledge of the facts.' (*Citation omitted.*) Nor in our judgment can the Board provide a fair hearing on an issue of negligence without identifying the standard of care and articulating the alleged deviation. Not only must the Board identify the standard and articulate the alleged deviation in order to provide the physician under investigation a fair opportunity to respond to a charge of negligence; it must do so in order to provide a reviewing court an opportunity for meaningful review.")

ANALYSIS

(1) *Whether the BOARD properly determined that Dr. Gibbs failed or refused to maintain adequate records on a patient? Were the records maintained by the doctor in his treatment of patient J.Z. so illegible and fraught with lacunae as not to enable reviewers to ascertain the treatment the doctor prescribed for the patient?* **Short answers: Yes; Yes**

93. The OMC, Dr. Harmon, found that Dr. Gibbs failed to chart whether he had discussed with J.Z. various treatment options.[165]

94. Further, Dr. Harmon determined that Dr. Gibbs' medical records were so illegible as to be indecipherable in part.[166]

95. Dr. Gibbs' expert, Dr. Kapner, had trouble reading Dr. Gibbs' chart of J.Z.'s treatment. He had to rely on his discussions with the doctor to understand that the Doctor had, in fact, discussed all treatment options with the patient prior to prescribing injection therapy.[167]

96. Dr. Gibbs, himself, admitted that he had not charted his discussions with J.Z. concerning alternative procedures.[168]

97. Dr. Mohammed, another one of Dr. Gibbs' experts, stressed the importance of a physician thoroughly discussing with a patient alternative procedures and attendant risks.[169]

98. From a review of Dr. Gibbs' chart of his treatment and care of J.Z., one would not know whether the doctor had discussed alternative treatments and their attendant risks. As Dr. Harmon put it, "if it's not written and documented in the chart, then it didn't happen."[170] In the very least, the lack of charting creates a negative

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[165] FINDINGS OF FACT, ¶24, above.

[166] FINDINGS OF FACT, ¶25, above.

[167] FINDINGS OF FACT, ¶77, above.

[168] FINDINGS OF FACT, ¶81, above.

[169] FINDINGS OF FACT, ¶47, above.

[170] FINDINGS OF FACT, ¶28, above; 11/16/06 HT at p.120, lns.21-22.

inference. Upon that negative inference, the BOARD acted justifiably by summarily suspending Lic. No. 13736 on August 25, 2006.

(2) *Whether the BOARD properly concluded that Dr. Gibbs engaged in conduct in the treatment of patient J.Z. that was or might be harmful or dangerous to the health of the patient? Does the standard of care require that the doctor have prescribed a less invasive regimen?* **Short answers: No; No**

99. The Complainant, Dr. Rahman, initially filed the Complaint under an impression that J.Z. had experienced a *priaprism* that, on its face (one week), was damaging. While Dr. Harmon testified that he was aware of the misimpression created by the Complaint, his MEDICAL CONSULTANT REPORT AND SUMMARY did not correct the error. Further, the erroneous impression was conveyed again in the BOARD'S August 25, 2006 "Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of [the Gibbs] License."[171]

100. As will be seen by a discussion of the next series of questions, Dr. Gibbs satisfied the standard of care in his treatment of the patient. As such, he did no harm. Moreover, it is not persuasive that he *potentially* caused the patient harm.

101. While his medical charting is deficient in content and legibility, the Doctor's testimony, supported by that of former patients, persuades that Dr. Gibbs probably discussed alternative procedures and their attendant risks.[172] J.Z. executed an informed consent. As a result of his having been informed, any harm that threatened J.Z. or was experienced by him probably resulted from his failure to act in conformity with the information and directives given to him by the Doctor.

102. While not dispositive, it is significant that no evidence was presented indicative that J.Z. suffered permanent harm. No testimony was forthcoming to that effect other than Dr. Harmon's reliance upon Dr. Rahman's assertion that the patient was unable to experience spontaneous erection during the period while Dr. Rahman had treated him.[173] However, no claim has been filed by the patient, a fact that

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[171] Exhibit S-15 (INTERIM FINDINGS OF FACT, ¶6).

[172] FINDINGS OF FACT, ¶¶ 30, 34, and 36, above.

[173] FINDINGS OF FACT, ¶27, above.

enhances the reliability of Dr. Gibbs' hearsay testimony concerning recent telephonic discussions with him.[174] Evidence is lacking persuasive of harm resulting from the administration of the ICI, other than the *priaprisms* experienced by the patient as a result of his own non-compliance. On this point, it is disconcerting that the patient was not contacted by the investigators.[175]

103. Testimony of the patient/employee witnesses persuades that Dr. Gibbs probably discussed alternatives with J.Z.[176] So also, the signed "informed consent" manifests compliance with the standard of care on the requirement that a physician obtain an "informed consent" to treatment.[177]

104. As Dr. Harmon acknowledged, *American Urological Guidelines* do not establish the standard of care for the treatment of ED or PE; they are guidelines.[178]

(3) *Whether the BOARD properly found that Dr. Gibbs engaged in conduct in his treatment of patient J.Z that constituted gross negligence, repeated negligence or negligence resulting in harm to or death of the patient? What constitutes the standard of care for a patient complaining of PE? Did the doctor's treatment of patient J.Z. fall below the standard of care? What is the standard of care for the treatment of priaprism? Did the doctor's treatment of J.Z.'s priaprism(s) fall within the standard of care?* **Short answers: No; No; and Yes**

105. As the previous discussions reveal, persuasive proof of harm is wanting.[179] While Dr. Harmon opined that penile injection therapy constitutes an invasive therapy that should not be used for the treatment of orgasmic dysfunction (PE)

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[174] FINDINGS OF FACT, ¶85, above.

[175] FINDINGS OF FACT, ¶15, above.

[176] FINDINGS OF FACT, ¶¶ 30, 34, and 36, above.

[177] Exhibit R-2(F).

[178] 11/16/06 HT at p.107, lns.4-8.

[179] FINDINGS OF FACT, ¶¶100 and 101, above.

unless an adequately informed consent is obtained,[180] Dr. Gibbs has persuaded that an adequately informed consent *was* obtained.[181]

106. That ICI falls within the standard of care for the treatment of PE was established by the testimony each of Drs. Mohammed,[182] Matthews,[183] and Kapner.[184]

107. That Dr. Gibbs prescribed an overdose in his test dose afforded J.Z. has not been proved.[185]

108. That Dr. Gibbs properly, within the standard of care, treated J.Z. for his *priaprisms* (January 11 and 25, 2006) was established by Drs. Mohammed[186] and Kapner.[187]

(4) *By treating J.Z. for PE did Dr. Gibbs practice beyond the scope of his practice?* **Short answer: No**

109. Despite Dr. Harmon's unawareness of the fact,[188] Dr. Gibbs has received training in the treatment of ED/PE with ICI, as well as the alternative treatment modalities.[189]

110. Additionally, while the May 31, 2006 "Statutory Notice Letter"[190] accused the doctor of practicing outside his scope of practice, the State has not established what that scope of practice is beyond which the Doctor had acted. As such, the State

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[180] FINDINGS OF FACT, ¶18, above; 11/16/06 HT at p.108, lns.5-23.

[181] FINDINGS OF FACT, ¶¶100 and 102, above.

[182] FINDINGS OF FACT, ¶42, above.

[183] FINDINGS OF FACT, ¶¶54 and 55, above.

[184] FINDINGS OF FACT, ¶¶ 62, 63, and 75 above.

[185] FINDINGS OF FACT, ¶¶ 22, 23, 50, 51, 58, and 82, above.

[186] FINDINGS OF FACT, ¶44, above.

[187] FINDINGS OF FACT, ¶¶71, 72, and 74 above.

[188] FINDINGS OF FACT, ¶28, above.

[189] FINDINGS OF FACT, ¶79, above.

[190] Exhibit S-8.

has not persuaded that a violation occurred on this count. No evidence was presented probative that Dr. Gibbs is prohibited from treating male sexual dysfunction.

CONCLUSIONS OF LAW

1. The *Board* has been delegated authority by the Legislature to discipline a license that it has heretofore issued for the practice of allopathic medicine in this State.[191]

2. Specifically, the BOARD is authorized to discipline a physician for acts and omissions constituting unprofessional conduct.[192] Within the statutory delineation of bases for discipline are included: A.R.S. § 32-1401(27)(e) "failing or refusing to maintain adequate records on a patient;" § 32-1401(27)(q) "any conduct or practice that is or might be harmful or dangerous to the health of the patient or public;" and, § 32-1401(27)(ll) "conduct that the BOARD determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient." The BOARD has chosen summarily to discipline the license because of the alleged violations. Its ORDER OF SUMMARY SUSPENSION issued on August 25, 2006 cited A.R.S. §§ 32-4201(27)(e),

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[191] A.R.S. § 32-1403 provides in part:

> § 32-1403. Powers and duties of the board; compensation; immunity
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> A. The primary duty of the board is to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional practitioners of allopathic medicine through licensure, regulation and rehabilitation of the profession in this state. The powers and duties of the board include: § 32-4254. Investigative powers; emergency action; disciplinary proceedings; formal interview; hearing; civil penalty
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> * * *
>
> 2. Initiating investigations and determining on its own motion if a doctor of medicine has engaged in unprofessional conduct or provided incompetent medical care or is mentally or physically unable to engage in the practice of medicine.
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> * * *
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> 5. Disciplining and rehabilitating physicians.
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> * * *

[192] A.R.S. § 32-1401 identifies the grounds for disciplinary action upon which sanction may lie.

(q), and (ll) as the bases upon which it had summarily suspended the license as an emergency measure.

3. The BOARD has been authorized by the Legislature at A.R.S. § 32-1451(D)[193] to act summarily to suspend a license when a threat to public health is identified.

4. While the STATE OF ARIZONA MEDICAL BOARD has been authorized to protect the public health and welfare by regulating those who practice allopathic medicine, the practice of the profession by those previously-determined qualified is their right, not just a privilege. As such, before the STATE OF ARIZONA MEDICAL BOARD may curtail that right, it must afford due process of law to the affected licensee.[194] The Arizona Court of Appeals has determined that a board satisfies the mandate of A.R.S. § 41-1092.11 that a post-suspension Hearing be *promptly* held, and due process duly accorded, by immediately advancing the issues to a formal Hearing.[195] Here, the BOARD issued its ORDER OF SUMMARY SUSPENSION on August 25, 2006. The BOARD thereafter issued its NOTICE OF HEARING on September 1, 2006. The NOTICE OF HEARING scheduled the Hearing for October 17, 2006. This timeline would seem to comport with the suggestions given by the Court of Appeals in *Dahnad v. Buttrick* and under the requirement that a Hearing be conducted at a significant time and in a significant manner.[196] It should be noted in this regard that Doctor Gibbs, rather than complaining about a delay in the BOARD'S provision of a Hearing, joined in a MOTION TO CONTINUE THE HEARING on October 16, 2006.

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[193] D. If the board finds, based on the information it receives under subsections A and B of this section, that the public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, the board may restrict a license or order a summary suspension of a license pending proceedings for revocation or other action. If the board takes action pursuant to this subsection it shall also serve the licensee with a written notice that states the charges and that the licensee is entitled to a formal hearing before the board or an administrative law judge within sixty days.

[194] *See Dahnad v. Buttrick*, 201 Ariz. 394, 398; 36 P.3d 742, 746 (App. 2001) (a case involving the Dental Board).

[195] *Id.* at 399 and 747.

[196] *Id.* citing *State v. O'Connor*, 171 Ariz. 19, 23, 827 P.2d 480, 484 (App. 1992).

5. The enabling statute further prescribes the nature of the penalty that may be assessed when proscribed conduct is identified.[197]

6. The issue presented concerns whether Dr. Gibbs has violated the standards established by the Legislature whereby conduct is circumscribed as either professionally acceptable or professionally unacceptable. Has the *Board* persuaded that Doctor Gibbs has committed an act or omission that warrants sanction? If so, what should be the nature and extent of the penalty?

7. The BOARD is required ("shall") to consider past disciplinary history in its assessment of an appropriate penalty once a violation has been identified.[198]

8. In this proceeding, the ARIZONA MEDICAL BOARD bears the burden of establishing that Doctor Gibbs has committed an act or omission making him susceptible to BOARD discipline.[199]

9. The legislatively delegated purpose of a ARIZONA MEDICAL BOARD oversight commission is to protect the public interest.[200]

10. The Arizona Legislature further has directed that statutes be liberally construed in an effort to effect their objects and to promote justice.[201] Technical words and phrases are to be construed according to their peculiar and appropriate

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[197] A.R.S. § 32-1451(N). The section reads:

> M. Any doctor of medicine who after a formal hearing is found by the board to be guilty of unprofessional conduct, to be mentally or physically unable safely to engage in the practice of medicine or to be medically incompetent is subject to censure, probation as provided in this section, suspension of license or revocation of license or any combination of these, including a stay of action, and for a period of time or permanently and under conditions as the board deems appropriate for the protection of the public health and safety and just in the circumstance. The board may charge the costs of formal hearings to the licensee who it finds to be in violation of this chapter.

[198] *See* A.R.S. § 32-1451(U):

> U. In determining the appropriate disciplinary action under this section, the board shall consider all previous nondisciplinary and disciplinary actions against a licensee.

[199] *See* A.R.S. § 41-1092.07(G)(2).

[200] *See* A.R.S. § 32-1403(A).

[201] A.R.S. § 1-211(B).

meaning.[202] The language of the governing statutes addressed herein have been construed and applied to protect public health and safety.

11. The State has persuaded by a preponderance of the evidence that Dr. Gibbs violated A.R.S. § 32-1401(27)(e) ("failing or refusing to maintain adequate records on a patient)."[203] The violation constitutes unprofessional conduct.

12. The State has not persuaded by a preponderance of the evidence that Dr. Gibbs engaged in conduct violative of A.R.S. § 32-1401(27)(q) ("any conduct or practice that is or might be harmful or dangerous to the health of the patient or public").[204]

13. The State has not persuaded by a preponderance of the evidence that Dr. Gibbs engaged in conduct violative of A.R.S. § 32-1401(27)(ll) ("conduct that the BOARD determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient").[205]

14. The BOARD'S ORDER OF SUMMARY SUSPENSION issued on August 25, 2006 reasonably and justifiably cited A.R.S. §§ 32-1401(27)(e), (q), and (ll) as the bases upon which it had summarily suspended the license as an emergency measure. Not only were the records illegible and virtually indecipherable, lacunae in the records reasonably led to negative inferences of negligence and unprofessional conduct. Although a face-to-face interview with the Doctor, as well as a conversation with the patient, may have ameliorated if not obviated the BOARD'S concern about care, the fact is that the records failed the standard.

15. Having reasonably drawn negative inferences from the medical records and having considered the Doctor's disciplinary history, the BOARD justifiably summarily suspended Dr. Gibbs' license on August 25, 2006.[206]

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[202] A.R.S. § 1-213.

[203] *See* FINDINGS OF FACT ¶¶92-97, above.

[204] *See* FINDINGS OF FACT ¶¶98-103, above.

[205] *See* FINDINGS OF FACT ¶¶104-107, above.

[206] FINDINGS OF FACT, ¶97, above.

16. A careful review of the totality and preponderance of the evidence presented at the Hearing of this Complaint supports discipline but not revocation of License No. 13736.

17. As a factor in mitigation is noted Dr. Gibbs' manifest cooperation with the investigators of the Rahman Complaint.

18. In aggravation is noted (1) the doctor's prior disciplinary history; (2) the magnitude and scope of potential harm to the public; and (3) inferred violation of his current probationary status.[207]

19. It is within the BOARD'S discretion to assess an appropriate penalty.[208] The BOARD is required to act reasonably after consideration of all of the facts and circumstances.[209] Having considered all of the facts and circumstances presented by this record, it is recommended that the BOARD suspend Lic. No. 13736 (time served) and require Dr. Gibbs to undertake additional hours per year CME training in the creation of competent and legible medical records.

RECOMMENDED ORDER

IT IS RECOMMENDED that the STATE OF ARIZONA MEDICAL BOARD suspend Lic. No. 13736 (time served) for violation of A.R.S. § 32-1401(27)(e).

IT IS FURTHER RECOMMENDED that the BOARD require Dr. Gibbs to undertake a minimum of six (6) hours per year, during the next three years, CME training in the creation of competent and legible medical records.

IT IS FURTHER RECOMMENDED that the BOARD dismiss allegations of violation of A.R.S. § 32-1401(27)(q) and (ll).

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[207] By the very nature of the term, a "probation" connotes a period of testing for continued fitness. *See* WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1806 (2002) : **probation: b** (1) **:** the action of subjecting an individual to a period of testing and trial so as to be able to ascertain the individual's fitness or lack of fitness for something (as a particular job, membership in a particular organization, retention of a particular academic classification, enrollment in a particular school)

[208] *See Maricopa County Sheriff's Office v. Maricopa County Employee Merit System Comm'n*, 211 Ariz. 219, 222; 119, 1025 P.3d 1022 (2005) ("[D]iscipline, initially imposed within standards and policies set by the appointing authority, should not be disturbed merely because a reviewing body sees it as disproportionate.").

[209] *Id.* at 223, 1026.

Done this 15th day of December 2006.

Gary B. Strickland
Administrative Law Judge

Original transmitted by mail this 15th day of December 2006, to:

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By